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Montana Board of Pharmacy

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Filling Prescriptions for Chronic Pain Patients

The Montana Board of Pharmacy receives several calls each month from pharmacists expressing concern about the rising quantity of narcotic prescriptions presented to pharmacies on a daily basis. Many of these prescriptions are written for large quantities of potent narcotics formerly reserved for terminal patients, yet many of the patients presenting these prescriptions are fully functional and ambulatory. Pharmacists in Montana, as elsewhere, realize that pain has historically been under-treated. It is estimated that more than 50 million Americans suffer from chronic pain. Inappropriate care of chronic pain can often lead to clinical exacerbation, increased suffering, and disability. We feel concern and empathy for patients in this situation. Beyond this realization lies concern about our professional obligation to do what is best for our patients. . . do no harm. The National Institute on Drug Abuse estimates that, in 1998, 1.6 million Americans used prescription pain relievers non-medically for the first time, and that nearly two percent of the adult (12 years and older) population of this country is currently using narcotics, sedatives, or stimulants for other than legitimate medical reasons.

Many health care providers have under-prescribed narcotics in the past because they overestimate the potential for patients to become addicted to them. Research has proven this fear to be largely unfounded. Studies have shown that the abuse potential of opiates is generally low in healthy, non-drug-abusing volunteers, yet concerns persist.

Suspicion that a patient is attempting to obtain a prescription drug for other than legitimate medical purposes can lead to a correct decision to not dispense. However, pharmacists can interpret patient requests for more medication as drug-seeking behavior, when inadequately treated pain is actually the cause. Purdue Pharmaceuticals has compiled an excellent sheet that defines key terms in pain management. It sorts out addiction, pseudo-addiction, and tolerance issues for health care professionals. Confusing physical dependence with addiction can lead to an exaggeration of the degree of risk of addiction among patients suffering pain.

Tolerance is defined as the need to increase the dose of a drug to produce the same level of analgesia. It is not equivalent to addiction. **Pseudo-tolerance** is the need to increase dosage due to other factors such as progression of disease or new disease, increased physical activity, drug interactions, addiction, or drug-seeking behavior. When an established dose of narcotic is no longer effective in relieving pain, the possibility of pseudo-tolerance should be excluded. **Physical dependence** is described as the occurrence of withdrawal symptoms following abrupt discontinuation of narcotics. It is not equivalent to addiction and not a clinical problem if patients are cautioned to taper off rather than abruptly discontinue these medications. **Addiction** involves the compulsive use of substances for their psychological or mood-altering effects. It should be considered if patients cannot control their drug use and continue to use drugs despite harm to themselves. **Pseudo-addiction** manifests as drug-seeking behavior due to unrelieved pain and stops when pain relief is achieved. Often this requires an increase in medication dosage. Such requests should be carefully assessed and met with renewed efforts to adequately manage pain.

The issue of under-prescribing narcotics and consequent suffering of patients has led to the development of guidelines for the treatment of pain. The Federation of State Medical Boards has published Model Guidelines for the Use of Controlled Substances for the Treatment of Pain. The guidelines have been adopted, in whole or in part, by many states in the past few years. The Montana Board of Medical Examiners acknowledges that many factors interfere with effective pain management, including exaggerated fears of addiction, fear of legal consequences, low priority of proper pain management in our health care system, and the lack of current knowledge regarding pain management. Their board does not want to hinder the proper use of narcotics, yet is concerned with improper use. They define treatment of chronic pain as multifactorial, adding that treatment with modalities other than narcotics should be utilized, "usually before long-term opioids are prescribed," and that "use of new or alternative types of treatment should be considered periodically for intractable pain in an attempt to either cease opioid medications or reduce their use." Their guidelines for the providers in Montana follow.

Guidelines for Prescribing Opioid Analgesics for Chronic Pain

1. **Thorough history and physical examination should be performed**, including assessment of the etiology of pain, physical and psychological function of the patient, substance abuse

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history, and other treatments that have been attempted to control the patient's pain. Identify underlying conditions and statements by all treating physicians that the patient's pain is intractable and not controlled by anything other than the use of opiates.

2. **Treatment plan**: A thoroughly documented treatment plan should be written, including a description of how treatment success will be evaluated. Several treatment modalities should be used in most cases and should be done concurrently with the use of opiates. Periodic review should be accomplished to determine that there are no other treatments that would be of additional benefit.
3. **Informed consent**: The physician should discuss the risks and benefits of the use of controlled substances with the patient and/or guardian on an ongoing basis, not just on initiation of therapy.
4. **Appropriate referral**: If treatment objectives are not being met or if the patient appears to be at risk for misuse of medication, refer to appropriate specialists, including addiction and chronic pain specialists.
5. **Documentation**: All recommendations and guidelines should be recorded accurately in the patient's medical records.

Pharmacists have a right and a responsibility to communicate their concerns to prescribers regarding medication use or misuse on an as-needed basis and to offer therapeutic suggestions. This can be done in a non-threatening manner. I recently became concerned about the slowly increasing narcotic use of an outpatient who, despite increasing medication, was not receiving adequate pain relief. I questioned him about other medications that had been tried in his case and discovered that he had not received an adequate trial of NSAIDs, despite having seen multiple physicians. He had no history of ulcers, allergies, or other contraindications, and his renal status was excellent. I suggested the addition of an NSAID, and the prescriber accepted the suggestion. The patient responded well, continues to enjoy a superior level of pain relief, and has been able to decrease his narcotic intake as a result. Other cases might not have enjoyed the same level of success, and new challenges would have been presented. The team of patient, provider, and pharmacist in this case was grateful for the outcome.

The Board is presently making plans to facilitate a statewide series of continuing education presentations on pain management for physicians and pharmacists and is looking toward the development of standards of practice for pharmacists filling narcotic prescriptions, which would be useful in everyday practice. Please contact the Board at 406/841-2356 if you would be interested in serving on a committee to help develop these standards of practice.

We encourage you to establish a dialogue with physicians and other prescribers to communicate your concerns and make suggestions when necessary. Prescriptions for large quantities of narcotics should always be evaluated for appropriateness. A potentially larger concern, however, is that of the patient who visits multiple practitioners and multiple pharmacies in search of narcotics. Within the limits of confidentiality, a concerned dialogue between pharmacists and physicians and among pharmacists themselves will go a long way in helping to solve this problem.

Board of Pharmacy Web site

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